PRINTED: 08/11/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN0503	A. BUILDING: _____ B. WING _____	08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION- FA	307 N FIFTH ST BOX 5477 MARYVILLE, TN 37801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During the annual Licensure survey conducted on 8/8/16 through 8/10/16, at Kindred Nursing and Rehab-Fairpark, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deanna D Hammontree
TITLE: Executive Director
(X6) DATE: 8-24-16

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